STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155126	A. BUILDING _____ B. WING _____	R-C 10/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDCO HEALTH AND REHABILITATION CENTER	**457 S SR 145 FRENCH LICK, IN 47432**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00155084 completed on August 28, 2014. This visit was in conjunction with a PSR to the Recertification and State Licensure Survey and the PSR to the Investigation of Complaints IN00154207 and IN00152458 completed on August 28, 2014. Complaint IN00155084 -Corrected Survey dates October 8 and 9, 2014 Facility number: 000054 Provider number: 155126 AIM number: 100287850 Survey Team: Sylvia Scales, RN, TC Terri Walters, RN Dorothy Watts, RN Amy Wininger, RN Census bed type: SNF/NF: 66 Total: 66 Census payor type: Medicare: 4 Medicaid: 48 Other: 14 Total: 66 Medco Health and Rehabilitation Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155126	A. BUILDING _____ B. WING _____	R-C 10/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 000}	Continued From page 1 PSR to the to the Investigation of Complaint IN000155084. Quality review completed on October 12, 2014, by Janelyn Kulik, RN.	{F 000}		